COLORADO
Department of Health Care Policy & Financing

Acentra HEALTH

Outpatient Prior Authorization Request Form - Confidential

Prior Authorization FAX: 800-922-3508
Acentra Health Customer Service Phone: 720-689-6340

This form is only for new or revised PARs submitted to Acentra Health. Unless providers have approval to submit via fax, all requests should be made electronically via the Atrezzo portal. Contact Acentra Health customer service at 720-689-6340 with any questions about this process.

☐ **New Request** ☐ **Revision – Prior Authorization Number _____**

☐ **Cancel – Prior Authorization Number _____**

Date of PAR Request (MMDDYYYY)

Billing Provider name: _____ _____ _____ _____ _____ _____ _____

Billing Provider NPI/Health First Colorado ID Number: _____ _____

Requesting/Ordering Provider Name: _____ _____ __

Requesting Provider NPI/Health First Colorado ID Number: _____ _____

Member Last Name: _____ _____ __ Member First Name:

Member Health First Colorado ID Number: _____ Member DOB: __

Does the member have primary insurance? ☐ **Yes** ☐ **No**

Primary Insurance Name: _____ _____

Does the member reside in a nursing facility? ☐ **Yes** ☐ **No** **Setting:** **Outpatient**

Service Type: ___ _____

(Service Types: PT, OT, ST, Personal Care Services, Genetics Lab, Imaging, PBT, Audiology, Wheelchairs & Accessories, Disposable Medical Supplies, Oxygen & Respiratory, Orthotics/Prosthetics, CRT, Oral/Enteral/Parenteral, Bedroom & Bathroom, Ambulation Devices, Hot & Cold Applications/Phototherapy/Wound, Trapeze Traction & Fracture Frames, Nerve Stimulator, Monitoring Equipment & Diabetic Supplies, Lymphedema Pumps & Compressors)

Durable Medical Equipment (DME) Supply Requests

Only member-owned equipment can be authorized for repair.

Serial number :
_____ _____

Indicate how long will this equipment be needed (in months and years). _____

Estimated cost of equipment: ___

Medical necessity for Service Requested: _____ **_____**

_____ _____ _____ _____ _____

Primary Diagnosis Codes and Descriptions:

Diagnosis Code	Description

Each service being requested must list each procedure code separately on this form.

Procedure Code	Narrative Description	Units Requested		Dates of Service	
				From (mm/dd/yyyy)	To (mm/dd/yyyy)

Additional comments:_____

_____

_____

_____

Contact Name: __ _____ _____ _____ _____

Contact Phone Number: _____ _____ _____ _____ _____

Contact FAX Number: